

Meaningful Use Workgroup
Draft Transcript
May 2, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody and welcome to a two hour call of the Meaningful Use Workgroup. This is a Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. A reminder to workgroup members to please identify yourselves when speaking.

Let me do a quick roll call. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Neil Calman? Art Davidson? David Lansky? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? Michael Barr? Jim Figge? Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Judy Murphy?

Judy Murphy – Aurora Health Care – Vice President of Applications

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Joe Francis? Josh Seidman?

Josh Seidman – ONC

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anyone off? Okay, with that I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good morning, everyone, and thanks for joining the call. We have three agenda items for today before our face-to-face tomorrow. The first was to review the stage two, category two to engage patients and their families, draft recommendations and reconciling them with the public comments. The second was just to recall the category five stage two recommendations that we approved in the HIT Policy Committee last meeting. The final one was in public and population health, to go over that 2x2 matrix having to do with labs and providers and hospitals that we talked about last call.

Then tomorrow of course we will be meeting face-to-face. A couple of major topics we'll be discussing there, one sort of a once-over in terms of all of our current draft recommendations in all the categories and then taking a perspective of the other HHS initiatives that we heard about in our last meeting of the Policy Committee, including the National Quality Strategy and the ACO NPRM. Let's see how we can align with those. There are some specific foci with very good emphasis that were called out in those programs and we want to make sure that we complement those.

The second major part would be dealing with the timing options we presented in the full committee a couple of meetings ago. After going through all of the draft recommendation updates, we said we'd come back and stay and take a look at it from a timing perspective, what flexibility can we afford while maintaining the momentum of the program, so we'll spend a good deal of time tomorrow on that as well. Any other questions, either about the agenda for today or tomorrow?

Okay, so we can begin today with an update on the engaged patients and families category two of our proposed draft recommendations. Christine, do you want to lead us through that, please?

Christine Bechtel – National Partnership for Women & Families – VP

Sure. I did some work over the weekend to try to understand where we were at, and, Paul, let me just say I understand your desire to simplify. I think where we ended up on the slide deck does not really reflect where I thought we ended up in our first face-to-face meeting and it's absolutely part of the confusion. Why don't I start by reminding people what I think that we agreed to? I'm going to do it by eligible hospital and then by eligible provider, because I think it's easier that way.

On the eligible hospital side, we talked about two criteria. The first is electronic discharge instructions, which we moved from a measurement or a threshold of being offered 80% of patients to being provided to some percent of patients, and I don't think we actually settled on the threshold, so we need a threshold there. The second is for eligible hospitals, is the ability to view and download information about their hospital visits within 36 hours of discharge. Now, I think here there's some confusion in terms of the slide deck, the 36 and 72 hours seems to be, I think, the confusion. My recollection is that the 72 hours was not actually the hospital side, it was something on the provider side because we recognize the importance of making information available to the patient and/or their caregiver quickly after discharge. So my recollection was that we retained the 36 hours and that was the other place where we looked at a usage threshold, which I believe was 10%. Let me stop there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Let's see, do you want to take them one at a time, maybe the electronic discharge instructions moving from offered to provided and then a question of whether there is a threshold associated with that. Comments?

Marty Fattig – Nemaha County Hospital – CEO

I think we need to be careful and make sure that we're some threshold of those that desire to have their discharge instructions electronically. Approximately 75% of our discharges are Medicare, and most of those would rather have paper.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think, and correct me if I'm wrong, Christine, that providers ..., that the service was available for them but they didn't have to use it. Is that right?

Christine Bechtel – National Partnership for Women & Families – VP

Yes and no. It depends on what we want to do. The stages one measure is provided 50% of the time to people who ask for it. The problem that we were trying to solve here was generating a proactive offer. So Marty's right that if we want to look at a usage piece as opposed to an offer here, that we would want to say that it's either a low threshold of everybody, like it's 10% of all discharges, so that you don't have to worry about patients who prefer paper. Or you have to define the denominator as patients who prefer paper, which does mean that they would need to, I assume, measure that in some way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments?

Christine Bechtel – National Partnership for Women & Families – VP

Marty, what do you think of a low threshold like 10% or 15% or something like that?

Marty Fattig – Nemaha County Hospital – CEO

I don't have a problem with that. The reason I say that is because if we have to have it available offering it and providing it is something we just simply do. It's not a burden on us.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Christine, by electronic you mean it's just the electronic version of the discharge instructions?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And they can provide it on paper?

Christine Bechtel – National Partnership for Women & Families – VP

We've always said we would never say you can't provide something on paper for a patient who wants it, but it would not count in your threshold.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I get a lot of pushback from our customers on this, like they're recording zero, they offer it and they get zero today. Maybe there will be more that want it electronically, but the other view that I get from the customers is these are really sick patients going from the hospital. They want a piece of paper they can carry out the door, the caregivers want a piece of paper, the instructions go to them rather than to the patient, so actually I'm more comfortable with stage two definitely making it an electronic version of the discharge instructions, but I'm just not sure it makes sense to offer to them electronically.

M

You're not sure of what, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We can put a threshold, but we're going to get a lot of pushback, is my expectation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Did you choose your words carefully? You said "not offered," which means—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Our customers will offer it, they do offer it. ... zero, so that's not scary.

Christine Bechtel – National Partnership for Women & Families – VP

Hold on, Charlene. Can we back up because—?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... on a piece of paper.

Christine Bechtel – National Partnership for Women & Families – VP

But Charlene they don't offer it today, so the measure in stages one is simply when a patient asked for it you delivered it half of the time. So they're not actually offering it under stages one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and these are for customers who do offer it. I'm just saying that they went that little bit higher of the bar, is the feedback I'm getting. I hear what you're saying.

Christine Bechtel – National Partnership for Women & Families – VP

Part of the strategy here is twofold, to make it useful to patients so that they do want it, and again that doesn't impact their ability to get anything on paper, but making it useful to them is really important. I think you raised another important point, which is the caregiver, and particularly in today's society where we have more and more remote caregivers, being able to have the discharge instructions electronically was what we had prioritized previously. The key is this is being able to view and download the discharge instructions electronically, which can be achieved through the same mechanism as the visit summary, and the question is how you measure. Do you offer it to 80% of patients or do you actually measure how many patients view and download on line?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think when you compare it to eligible providers and you try to make the transition to use and we put the 10% threshold in, that's something where we do have quite a bit of industry experience, and at least many of us feel that the 10% is an achievable and a reasonable threshold ... low. I think on the hospital side you can imagine people as they're leaving the hospital who don't have a computer in their hands so they would like to look at this thing generally on paper, as Charlene was saying. So I think we have two different kinds of use case and preferences where it's most convenient. I think that's where we're struggling with it.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but I think what I'm also struggling to clarify is that this is not an either/or. This is, okay, here it is on paper so you can take it with you. Do you also want this delivered to you electronically within 24 hours so that you can share it with your doctor, you can download it again and print it out if you lose it, whatever. I feel like we're debating a criteria that, A) is already in stages one; and B) we already agreed in our last in-person meeting to preserve. So the question is simply how to measure it, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and that's a bit challenging in the hospital

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Can they just hand them a USB card or something and count that as being provided? Ten percent sounds pretty high actually, because I don't think I would carry the—I just want my thing on paper when I'm leaving because I want to read the thing I'm going to execute in the next day or two and then move on to the next thing. These are discharge instructions, not my whole record, so I think 10% may still even be high for actual. But if we're just handing someone a USB drive then I guess, or a CD or something, then, I don't know, we're kind of moving away from the purpose of discharge instructions, which is to make sure that the patient is engaged in their care and follows them. We're kind of now moving towards a different goal, which is encouraging patients to be more electronically oriented, which is a different goal.

Deven McGraw – Center for Democracy & Technology – Director

It is. I'm wondering if there's a way—because, George, I don't like to force people to use electronic mechanisms if they're not comfortable, but I like directing at least the machine capabilities to make it available electronically, even if patients ultimately would prefer to get it on paper. So I'm wondering if there's a way to frame this so that that capability for electronic view and download is there. For patients who prefer to either get it electronically only or to have it available electronically after they leave if they lose a piece of paper, that they ultimately ask for, or they've got a caregiver relative who wants to re-consult the discharge instructions after she's gone back home and left mom on her own and would prefer to have them electronically. So ultimately there are two goals. One is the capability in that the electronic version is there and people want it. But ultimately I think we do want the information in the hands of patients and if they prefer it on paper that should count.

Christine Bechtel – National Partnership for Women & Families – VP

Deven, I don't disagree with anything you said. But the issue is how do you measure that because part of the problem that we have in stages one and ... is that patients do not know to ask for an electronic copy if they want one.

Deven McGraw – Center for Democracy & Technology – Director

No, this is upon request. It is handed to them or they're told where they can get it electronically, both and actually.

Christine Bechtel – National Partnership for Women & Families – VP

I think in some ways that probably a better strategy for this would be to tie it into the hospital visit summary, because that is something that patients are going to find a lot more useful, downloadable, shareable with their primary care provider, with their family caregivers, whatever. The problem I have with linking them, though, is that it does not appear that there's a lot of belief that hospitals are somehow capable of doing that in stage two, and hence that could be a menu item. I'm really uncomfortable with the idea that, first of all, hospitals only have two patient and family engagement criteria in stage two and only one of them might be core. Otherwise, if they were both core I would say, if we're making information available on the hospital visit summary to the patient after discharge, then let's fold these two criteria together, but I'm only really comfortable if that hospital visit summary is in the core.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Isn't that our default, though, is to move these things into core?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The hospital visit summary is new.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. So far we have not talked about, and we will talk about tomorrow, in the timing discussion whether having this kind of menu in core helps that and yet achieves our goal. I think—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... to a higher level in this one. As we look at the use case here, the patient's going home, there's two types of documents we're talking about, discharge instructions which they really need and then this view and download, and I want to talk about view and download information. On the overarching piece we get a lot of pushback on the readiness of hospitals to set the infrastructure up and a lot of concern because of the security and privacy to provide access. So that's going to be a lot of work to set that infrastructure up for either of these cases in terms of accessing the information. So that's one element of it. I think the other element of it then is what's the overlap and the multiple purpose of these two pieces. It's like why do you need a summary if you've got the discharge instructions. If you give them two things it just gets complex and the real thing we want them to have, it strikes me, is the discharge instructions.

Christine Bechtel – National Partnership for Women & Families – VP

I disagree with that strongly, Charlene. I think—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

From the hospital?

Christine Bechtel – National Partnership for Women & Families – VP

Yes. It's one thing to know what you need to do when you leave, but it is an entirely different matter to know what was done to you in the hospital and all of your test results and things that are still pending that get delivered later, how you share that information with other members of your care team. That is a much richer data set that's really important for patients to have to manage their care. I'm also very cognizant of what Paul has spent a fair amount of time talking about, which is the limited value and utility of many of the hospitals today, their discharge instructions now, because they're so generalized. A hospital visit summary is really the companion piece to the EP's information and being able to back up to your health information, download it, move it, and aggregate it, particularly in the long term as well, is hugely critical. The visit information is going to be, that's what I'm suggesting is if that were actually in the core then the discharge instructions could be very easily, since they already have to have the ability to do it in stages one, simply made available through that same mechanism.

Jim Figge – NY State DoH – Medical Director

I have a suggestion for how to measure the discharge instructions. I'm looking at the Medicare ePrescribing program and it's pretty straightforward in that program. They only look for 25 ePrescriptions from a physician over a year and right now, up until the end of June you have to do 10, so there are no percentages involved. It's just a simple count. CMS knows that if you do 10 or you do 25 over the year then you're doing ePrescriptions, and I think we can just do something very simple like that for the discharge instructions, pick a small number and if the hospital can show that they've given that many electronically then you know that they can do it. I think that's all we really want to know is can they do it, is it available. I don't think we need to have anything fancy for this, just a simple count just to know that they're doing some.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How do people feel about that suggestion?

Deven McGraw – Center for Democracy & Technology – Director

Jim, is the count electronic view and download? What's the number?

Jim Figge – NY State DoH – Medical Director

For the discharge instructions?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Jim Figge – NY State DoH – Medical Director

Whatever modality they're doing, discs or Flash drives, whatever it is that they're giving out just to document that they've done at least "x" number of those, where "x" is a small number, and then be done with this. If you can automate it, it's better, if it's an automated report, so that you don't have to do a lot of number crunching to come up with a percentage.

Christine Bechtel – National Partnership for Women & Families – VP

Jim, I understand and appreciate the simplicity and elegance of that notion. I think the challenge that I'm really having is having listened to the enormous amount of pushback that the hospitals have expressed around not even having to offer this to their patients. I'm struggling to balance the real need for hospitals to actually engage patients and their patients in telling them, hey, you can have this electronically as well if you would like. Versus the need to just say, well, gee, I've really only got to give this to 100 people this year and so let me pick the 100, but I don't have to tell everybody else. How do we reconcile both?

Jim Figge – NY State DoH – Medical Director

I think you're asking a different question. You're questioning whether we should even have this in the set of criteria, and I'm saying if it's going to be in there then I'm suggesting a simple measurement.

Christine Bechtel – National Partnership for Women & Families – VP

No, I'm not questioning whether it should be in the criteria. I think that was maybe Charlene.

Jim Figge – NY State DoH – Medical Director

I'm just judging from the experience that CMS has had with the ePrescribing program and Medicare. They typically know that if somebody is doing this, if you can document that you've done it 25 times they know that you're generally doing it. I think that's all we really want to know right now. I don't think we need to make this fancy.

Deven McGraw – Center for Democracy & Technology – Director

Is that the meaningful use criteria for ePrescribing is 25? I don't remember that.

Jim Figge – NY State DoH – Medical Director

Yes in Medicare. Not meaningful use, the Medicare ePrescribing program. It's a different program, but that's the criterion.

Deven McGraw – Center for Democracy & Technology – Director

We've never had any pure numbers in the meaningful use.

Jim Figge – NY State DoH – Medical Director

No, but what I'm suggesting is that we should because it's a simpler way of reporting and it just documents that you're doing it. To try to calculate denominators is very tough on some of these things and from my perspective, from the Medicaid agency that has to audit this, it's a nightmare. We don't know how to audit a lot of these things other than sending people in and going through records, which we don't want to do. So the simpler you can make the reporting, just to show that it's happening, the easier it is on both sides, both on the auditing agency side and on the provider side.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You'll recall that one of the things we talked about at the full committee, I believe, is the purpose of these regs is really to make sure things are available to the patients and consumers. It's not really to force specific thresholds, because in a sense if it's of value then it will generate a demand. This very much parallels our patient portal ... once the community, meaning the patients and consumers, understand that this is available, they start demanding it. Our goal here was to make sure that one, the EHRs have the functionality, and two, that it is used where people want that. So that's I think to kick start and once you have a threshold that's the other thing we talked about last meeting was it's not as if people want to say, oh, I've reached a 30% threshold, for example, now I can just stay there, because if it's of value then the consumers will demand it.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, that's my problem. I agree. The issue is, and you said the exact phrase, "once they understand it's available they'll demand it." This is not something they're accustomed to, so what I was trying to figure out how to straddle with Jim's suggestion was how do you ensure that there is continuing demand? You have to talk to them about it, which hospitals do not have to do right now. So that's what I'm trying to balance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The other thing that happens is that it becomes actually part of the I think part of the mission for ONC and HHS is to help the public understand that you can get this information currently and here's what you can do with it. I think that's something that goes on in parallel and does happen naturally in the private markets as well. As I say, one experience of that is patient portals and PHRs. I think we're just making sure that everybody has the capability and start that process and from just a simplistic logistical way Jim's citing the eRx separate initiative, well, you can just count that a certain amount of ..., that means that that function exists and that you are using it.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

I'd rather have them attest that they're offering it to 80% of patients and then either just report the number who have used it, or have to meet some minimum number, which is what James is suggesting. But I think it's got to be both if you go with a number. If you go with a percent threshold of use, as we've talked about previously, that's what requires them to tell everybody. If they know that they need 10% of discharges to actually use this, then that will trigger what we've done before with EPs, and that's fine. But if the idea is to go with a count number, then I think you need to couple it with an attestation that they have offered it to 80% of their patients.

Jim Figge – NY State DoH – Medical Director

The problem with offering it to 80% of patients is that I don't know how you audit it. I can tell you, our auditing agency in New York is looking at tools like sending in undercover agents posing as patients to see if things are being offered. Is that how far we really want to go with these things? Because if you have vague criteria like that, it's the only way we can audit them. I don't know that we want to send in undercover agents posing as patients, but that's what will happen if you have criteria like that, because there's no other way to audit it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Could I step in here? We've used up half an hour on this and it is something I don't know that we're going to get complete agreement on, and maybe we just need to have a sense of the members in terms of how to move forward on this one. I think we have two issues. One is making sure that the functionality is used, and the other is whether it is offered to some percent of folks. Can I start with the functionality exists and is used and I think the latest recommendation that Christine also ... from the use point of view is a comfortable number, which makes the denominator problem easier?

Christine Bechtel – National Partnership for Women & Families – VP

Only if it's coupled with an offer.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I understand.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, today the piece, the way it's done is that it can be produced electronically and in some cases customers, it's just evolving to give Christine some assurance in terms of what's really happening out there. It's now starting to step up to be part of hospital policy so that when you do an admission you start to ask. Now, we recognize a lot of patients come in through the ED so it's not possible, so we have to consider that. But bottom line is today it's offered and you can provide it in any modality, and there are a lot of modalities out there. Some hospitals have view and download, some have USBs, they're texting people now because there are whole new modalities, but is the intent still to make it flexible so that the hospital can offer that electronically in whatever modality—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. I think to maintain the flexibility we're trying to get this information in an electronic fashion and in a usable form.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

That's what I'm for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. Okay, can we have a sense of the group in terms of from the use point of view, and I understand Christine's vote is linked to offer, anybody else want to vote for having a countable use metric? I think that makes sense.

Christine Bechtel – National Partnership for Women & Families – VP

Say it again.

W

I'm not sure what we're voting for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So there are proposed two dimensions to the discharge instructions. One is that the functionality is there and is being used in countable numbers. The second is that this capability is offered. So right now we're just voting on the use of the countable number, and Jim, do you want to pick a number?

Jim Figge – NY State DoH – Medical Director

I'll just say 25.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That electronic discharge summaries are used by 25 people in electronic form for the hospital.

Jim Figge – NY State DoH – Medical Director

Discharge instructions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Discharge instructions, correct. So those people accepting that?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Does that mean 25 is the threshold?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly, 25 would be the threshold.

Christine Bechtel – National Partnership for Women & Families – VP

I think it's too low.

Marty Fattig – Nemaha County Hospital – CEO

I will have to put it on some sort of media and give it to people, because 25 will not ask for it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's fine, too. We remain flexible on the electronic media that is provided to patients, that some countable low number that says that you have ... is being used.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, we've got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Charlene, is that a yes?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Marty?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

The customers will say the same thing, but they can do it.

Marty Fattig – Nemaha County Hospital – CEO

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes, it's doable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I think the number's too low, but I think if it's linked to also offering it so that we really make sure that more than 25 or whatever number of people know about it, then I'm okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so yours is a contingent vote. I'll vote yes. Marty?

Marty Fattig – Nemaha County Hospital – CEO

I was a yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Who have I missed?

Deven McGraw – Center for Democracy & Technology – Director

Deven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Deven?

Deven McGraw – Center for Democracy & Technology – Director

I think what I'm struggling with is whether setting a number that is low and reachable still is going to be enough to provide incentives for people to actually offer it so that they know they can hit their number 25. Because while I'm definitely sympathetic to where Christine is headed, also I understand the points that Jim is making about how you would measure and audit a percentage of offer. It's absolutely what I want to have happen. In fact, I don't want 80. I want 100. I want it offered to everybody. So what I'm struggling with is whether setting an actual use electronic number requires them, in order to make sure that they're hitting that, to actually do the kind of offering that I want. Which is that every patient is offered it so that they make sure that they hit their 25, especially if 25 is about use and not offer. I'm inclined to agree with the proposal on the table, but I want it explained that that's the theory.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. And I think many of us hold that same theory. Anybody else that I've missed?

Judy Murphy – Aurora Health Care – Vice President of Applications

I agree with setting a number because I think counting the offers would be tough.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I'm not sure I entirely agree, because certainly you could probably reach 25 and just report that I have 25. But I'd rather see that there's reporting beyond that 25.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The reporting would be there and then in order to qualify for meaningful use you have to at least have 25.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Okay, thank you.

Judy Murphy – Aurora Health Care – Vice President of Applications

The reporting had to be there this year, because it's a core criteria.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So everyone voted in favor of it except for Christine, which had a contingent on the second vote, which is going to be on offer. Christine, do you want to offer a threshold for your offer criteria?

Christine Bechtel – National Partnership for Women & Families – VP

Well, I think it's 80%, but it's coupled with the count. It is not an only 80% attestation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so what are people's feelings on that one?

Christine Bechtel – National Partnership for Women & Families – VP

It would be measured through attestation, which is how a lot of what we have in here is already measured, so let's not hold this to a higher standard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Let's vote on it as a separate requirement so that we can separate the two, and I understand that Christine might link them—

Christine Bechtel – National Partnership for Women & Families – VP

Yes. Paul, I'm not proposing that. I don't want to vote on an 80% offer. That's not my proposal. If somebody else wants to propose it, you can vote on that. But my proposal is that they are linked together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's vote on that then. Christine obviously is a yes. Others?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Are we voting on the combination?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

On the combination, correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'll vote no because of the ED element of it. There's a lot of concern there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Others?

Marty Fattig – Nemaha County Hospital – CEO

I have the same concern with the ED.

Christine Bechtel – National Partnership for Women & Families – VP

Is there a lower threshold that gets you more comfortable?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me continue the vote. We've got to move on. George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I'm actually either offer or a count, but not both.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so that's a no on the combination?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Judy?

Judy Murphy – Aurora Health Care – Vice President of Applications

No, on the combination as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director

I would vote yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And Deven?

Deven McGraw – Center for Democracy & Technology – Director

Again, I think that, going back to what I said before, it's hard to vote on this choice. Because my theory is that the capability, number one, assuming that the capability for view and download is present and it would have to be there, if they've got a hidden number then I think they need to offer it to all of their patients in order to hit that number. So I wouldn't couple it with an offering threshold, because even though I get that all of this stuff is attestation you're still subject to being audited as to whether you attested accurately to 80%. I'm struggling with how you measure that in an offer context when ideally it should be offered to everybody. It either is or it isn't.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, the number is 25, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Deven, it sounds like, and I think I would agree with exactly your rationale, which is if people are going to use it then they will generally want to offer it. That's the most logical thing to do.

Deven McGraw – Center for Democracy & Technology – Director

If you have to hit a use number, so I would put the number at actual electronic use. By the way, I'm not that fond of people being handed USB sticks because they're not very secure, but that's another issue.

Christine Bechtel – National Partnership for Women & Families – VP

Just to be clear, Deven, this is not necessarily view and download. This is ED, this is secure e-mail—

W

Whatever modality.

Deven McGraw – Center for Democracy & Technology – Director

This is why I want to talk about what the capabilities are in this minimum capabilities in the system, versus allowing people some flexibility with respect to how, from a meaningful use perspective, they meet getting patients' electronic versions of their data, affirmatively getting them, not in response to requests. I guess I'm parroting a discussion that went on in the Information Exchange Workgroup where there was a strong

desire to give institutions, and patients, quite frankly, some flexibility with respect to how they receive electronic information. But have the capability, like a portal, for something that is available through a view and download functionality even if it's not always the mechanism that's used to electronically communicate with patients, a lot of times due to patient preference. So there's a lot more packed into my answer. I am not all that keen on the idea of 25 patients being handed USB sticks.

Christine Bechtel – National Partnership for Women & Families – VP

I completely agree. I think it is a separate issue and it flows throughout each of these whether it's a visit summary, a clinical summary on the EP side, what is it we're giving them. Because it's that discrete computable data that they need, so I think it's an issue that we need to settle on so that we know what we're talking about here.

Neil Calman – Institute for Family Health – President & Cofounder

I just wanted to let you know I joined about five minutes ago.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Neil, did you join the conversation enough to know what you want to vote on this one?

Neil Calman – Institute for Family Health – President & Cofounder

No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Deven, do you want to record a vote on the offer?

Deven McGraw – Center for Democracy & Technology – Director

I don't, but I'm also wondering whether we're all on the same page with respect to the vote on the previous measure, if only because I had a lot of assumptions built into my vote that might not be shared by everybody else in terms of what exactly is the electronic capability that we're talking about here. I really don't want 25 people being given USB sticks to check the box.

Christine Bechtel – National Partnership for Women & Families – VP

That's what's going to happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Did I miss anybody on the second vote?

Jim Figge – NY State DoH – Medical Director

I vote no on the combo.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I'll vote no, actually parroting the reasons that Deven had. I think we have the majority, Art and Christine voting yes for the combo, so I think that would mean that using the earlier vote that we would use the counted 25 use of electronic distribution of discharge instructions as the proposed criteria to discuss in the full committee still. The next piece, Christine, was your view and download, and the information is from the hospital visit and one of the questions was 36 hours versus 72 hours and the threshold was 10% using it for the—

Christine Bechtel – National Partnership for Women & Families – VP

Right, and that was pretty well settled in our last face-to-face.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think the only opening was the 72 versus 36, and I believe the argument from what we heard from the hospitals was 72 hours, by their processing, the things that go on after someone's discharged, was more reasonable than 36 hours.

Christine Bechtel – National Partnership for Women & Families – VP

Are we talking business hours?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, someone else can correct me, but I think these are real hours because a hospital is a 24/7 operation.

Neil Calman – Institute for Family Health – President & Cofounder

I thought we had decided that we were going to release the information right away, but that we were going to call out the fact that it was going to be iterative, that people would know that that information would be available again, right, at a later point as more information came?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that was my summary.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

There are two issues. One is how long does it take them to get your ID the first time and how much of a break do they need on that? Two, once the patient has an ID, how delayed is the information? So there are two different timings.

Neil Calman – Institute for Family Health – President & Cofounder

To get an ID, that can be done while the person's in the hospital in preparation for discharge. It doesn't have to be done in the discharge office.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

If the patient calls the hospital from home, what's the timing to be able to return that ID to the patient, I guess, would be the thing?

M

The point being that if we pick a long number then it should cover both. If we pick a short number then we just need to consider that. Actually, there are three issues. One is when the lab data has been reviewed when the stuff that's already in there should be viewable right now, immediately, and how long it takes to get the ID.

Neil Calman – Institute for Family Health – President & Cofounder

I don't think calling from home is going to be a workflow that's going to work, because how would they identity proof the patient? How do they know that who's calling is actually the person? You have the face-to-face availability in the hospital so I would think somebody would just issue the patient the ID while they're in the hospital and say here's how you access your records once you get home.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Shouldn't that ID be part of the discharge summary so that they—

M

....

Art Davidson – Public Health Informatics at Denver Public Health – Director

... go off and get it?

M

Let's not solve that problem. Insofar as the time, Neil, you're saying that 24 hours is fast enough, and we had said consider 72; 24 hours to be able to see information already in the records. I'm trying to understand why you need any time. If you hand somebody the information that's already in the record, which we say there's a lot of information already in the record at the time of discharge, somebody should be able to access that immediately, with the understanding that that information pool is going to grow as labs come in and additional information comes in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think there's also a coding issue, the actual final discharge diagnoses are often done in HIM, and I think that's part of it.

W

Paul, I really don't think we should wait for those. Oh my goodness, that's like—

M

That could be weeks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's go back to the 36 versus 72.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It strikes me that the process issue in terms of how the hospital sets up access to the information, and again if you're an inpatient there it's one thing, if it's an ED patient then it's another, but if you're an inpatient and they set your account up when you're there, then it's definitely a viable situation. But it's that process to set your account up and identify you to make sure that you can access the information that is the critical path here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The most likely time is before you leave the hospital, and of course that's when you—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Or on pre-reg for those inpatients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure, that's true too.

Christine Bechtel – National Partnership for Women & Families – VP

Well, I'd like to remind folks too we talked about stages three people having real time access in the hospital through kiosks, etc., for family members and things like that. So it seems to me that 36 hours, you need to have the workflows in place anyway for a speedier time, and as we all know, time is of the essence here when it comes to discharges. This is something we have already agreed to twice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's do the 36 and then I see that we also considered switching this to a usage instead of offer.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and we did agree to that in our last ... meeting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Any other discussion there? If we've already done it, we've done it. So this would now be that 10% of patients view and download information from the hospital visit within 36 hours.

M

Wait a minute—

Christine Bechtel – National Partnership for Women & Families – VP

That's not—

M

... it's 10% of patients you would download information, they can do it within 36 hours if they want but we don't need to—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So within 36 hours of discharge information is available for patients to view and/or download, and 10% of them take advantage of that, not necessarily within 36 hours. Yes, okay, we need to find a better way to bullet that, but that's the point. Do you want to go on to another topic, Christine?

Christine Bechtel – National Partnership for Women & Families – VP

Sure, so we're now on the EPs, so this is where I think, Paul, you were really asking for clarification. In the slide deck there are really four things that are actually condensed into two. We decided to integrate electronic copy into view and download, so that is no longer there. I don't understand the personal health record one. I don't know where that came from. Let me articulate my—the agreement that we have from our last ... meeting with respect to the other two criteria and then if somebody realizes what this EHR thing is, if it's different we should talk about that. There are two kinds of electronic access view and download criteria. One is being able to view and download the more longitudinal health information, so being able to go, any time I want, into my record and see relevant information about me and being able to then download that and take that with me.

The second piece is the view and download of the clinical summary, what was called the clinical summary in stages one, what I think we began to call the encounter in stage two, but I believe it's the same thing. In stages one the view and download of longitudinal information is an existing criteria. Ten percent have access to information that is available within four days of it being available to the practice, and that is a menu item. So what we agreed is to change the terminology from access to view and download, to have it be the same threshold, the same time period, but move it into core.

The second piece is the clinical summary/encounter. That is a core requirement already in stages one. It is information about the visit that is available within three business days and in the RFC we suggested going to 24 hours and it stays in the core. Now the remaining issues are what are the discrete computable data that are included, because that was where we did not define things with respect to view and download of longitudinal data, we did not define that in stages one, but we did in the RFCs. The clinical summary was actually defined pretty well in stages one. Is everybody tracking?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'm not sure.

Christine Bechtel – National Partnership for Women & Families – VP

Let me put it this way, the first piece is the larger data set that patients have access to. It is information that is from previous clinical summaries and encounters, as well as current, so that you can have a more longitudinal view over time. That's the piece that is already in stages one, that is what we intended, but we did not define the data set and we did not have a download capability and it was a menu item. So in this case we had suggested a definition in the RFC, which I think we probably need to look at, but not on this call. We agreed already it's a view and download capability, and we agreed already that it goes into core. That's the first piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Actually, let's just take them one at a time so people don't get confused. That's actually moving access before it was terms of access into a view and download and from menu to core and with better definition of what are the elements in there. Did I get that right?

Christine Bechtel – National Partnership for Women & Families – VP

That's exactly right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I think the only, and just because of the feedback I've heard from the people operationalizing this, that definitional piece in terms of the expectation of the longitudinal view, I do not think it's the case. There's a lot of question and confusion about that, so just to clarify that. The intention may be there but it would be the data that's available for that venue, not the longitudinal data.

Christine Bechtel – National Partnership for Women & Families – VP

We did not define that in stages one and should have, so that's the piece that we need to—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So there's a gap there. Whatever's available in the record would be available, but not a longitudinal view.

Christine Bechtel – National Partnership for Women & Families – VP

I'm not sure what—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

You can't get it. How are you going to get it? Some is in the hospital. Some is in another physician practice.

Christine Bechtel – National Partnership for Women & Families – VP

This is specific to the meaningful use position?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

It's not longitudinal like aggregated, it's longitudinal from within your practice. So it might contain information from an encounter six months ago.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Again, that's probably variable too.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, which is why we need to define it and which we proposed a definition that we need to just land on. Paul, do you want to move to the second one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Do you want to vote on this one first?

Christine Bechtel – National Partnership for Women & Families – VP

We already did.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, fine.

M

Actually, you've got to tell me again because on the slides it says – are we doing longitudinal or clinical encounter right now?

Christine Bechtel – National Partnership for Women & Families – VP

The more—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

What we previously accessed.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

M

Okay, so what are our thresholds for this, what are we voting on?

Christine Bechtel – National Partnership for Women & Families – VP

It is the same as stage one, 10%, but you move it from menu to core. It's 10%—

M

Yes, yes, okay, good.

Christine Bechtel – National Partnership for Women & Families – VP

It's 10% you're actually using.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Christine, the reality is, and I don't know how we're going to work through this—

M

Charlene, can you speak up, please?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, the customers that implement this in the practices, they don't like just viewing their data. They want exactly what you said, but they can't get it today. So if an HIE came to town that had the longitudinal view, that would be their preference. How do we give them what they really want ultimately? We don't want to preclude that with this criteria, is all I'm suggesting.

Christine Bechtel – National Partnership for Women & Families – VP

That's what the download piece is about. The download function was designed so that you could download from your OB/GYN but you could also download from your primary care provider and have it into one place that you choose. We definitely would not want people to not go through an HIE but then they would still need to be able to view and download from the HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thanks, Christine. Do you want to move on to the second one?

Christine Bechtel – National Partnership for Women & Families – VP

The second one is a clinical summary. This is a stages one core requirement already and it was fairly well defined. I'm going to check really quick, it's a stages one requirement already and the timeline is three business days. The threshold is provided to patients for more than 50% of office visits, again, within three business days, that's the stages one piece. This would stay the same, which is exactly what I just read, although we had agreed in the RFC to have it be within 24 hours of the encounter rather than 3 days, or within 4 days of the date of becoming available to the practice such as in the case of labs. That's what we proposed in stage two and agreed to in the face-to-face, and that's the, what row is this on here? One, two, is it six, no. I don't know where it is on here. But anyway—

M

It's the third row.

Christine Bechtel – National Partnership for Women & Families – VP

... encounter. Oh sorry, third row.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I'm just looking over our notes from the in-person. I see, so what happened is we put in 24 hours, the majority asked for an extension, our summary of our conclusion says consider 72 hours, and that is either Paul or Josh's comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

These aren't mine, so I assume it's Josh.

Josh Seidman – ONC

I think it was just an open discussion as to, I don't think there was a decision as to whether it should be 24 or 72 hours.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But Christine's right, we had said 24 and then the feedback ... summarized it as a majority of commenters suggest it extend 24 hour timeline to 36 or 72 hours. That's the only thing that's left open, is that right? You don't think it's open, Christine, I know, but there's nothing else left open, is there?

Christine Bechtel – National Partnership for Women & Families – VP

That's right. Yes, I think that's the only open thing. It's 72 hours, it's 3 business days. Well, I guess it depends if it's 72 business hours or not. stages one is already 3 business days and we had talked about shortening that to 24, so if people from the RFC think that's not quite enough, maybe we should do 36 and we need to think about whether that's calendar or business hours. Neil, in your practice when you provide a clinical summary what's the time frame that you operate in today? Neil Calman, are you on?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I'm sorry. I was on mute. I was talking to myself again.

Christine Bechtel – National Partnership for Women & Families – VP

Oh great, well talk to us.

Neil Calman – Institute for Family Health – President & Cofounder

No wonder nobody was listening.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

We provide an after visit summary at the time of the visit that has whatever data we have. It's not a longitudinal summary, it's basically an encounter summary. But it has some information that you can consider longitudinal, like things that are starting and stopping, medications and things like that. But that's provided at the time of the visit and we're moving to including the progress note from the current visit. But that's all we provide at the time of the visit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I agree with that too. Looking at this list, all of these things, short of the progress note itself, pretty much are updated at the visit. So, for example, problems with medications, immunizations, those are things that you typically order as part of your encounter because they would almost have to be closed by the time the patient leaves. So it does seem like the information that's listed here is available in ... progress notes.

Josh Seidman – ONC

Right. I think the intention is that things that are ordered at that time can be put in as ordered, so if there's a lab ordered then that could be put in as ordered and then information later can be passed along.

Neil Calman – Institute for Family Health – President & Cofounder

Exactly. Then the information is available to people through our patient portal afterwards. I don't see any need to delay this. This should be instant.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I think we're, at least this group is going back towards 24 hours, and I think we're arguing that the information that's been called for are things that are transacted that day and almost have to be in the EHR.

Neil Calman – Institute for Family Health – President & Cofounder

How would somebody get it 24 hours later?

Christine Bechtel – National Partnership for Women & Families – VP

Potentially through the portal.

Neil Calman – Institute for Family Health – President & Cofounder

That's calling out the need for a portal then to do this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Christine Bechtel – National Partnership for Women & Families – VP

But that's not new, because stages one has this at within three business days, so there's been a question of how to get it.

Neil Calman – Institute for Family Health – President & Cofounder

I guess within three business days you could probably mail it to somebody.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

But you couldn't really do that in 24 hours. Basically we're circling around the issue, but basically to meet this you're basically saying to people unless you're going to give it to them at the time of the visit that they're going to have to access it through a portal to get it within 24 hours.

Christine Bechtel – National Partnership for Women & Families – VP

Or secure messaging, I guess.

Neil Calman – Institute for Family Health – President & Cofounder

Maybe. Yes, I guess you could do that too.

M

I think some of that remote access is for family members. Family members can access electronically through a portal or secure message after a visit.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I don't know if you're hearing feedback, we're hearing feedback, and again this is just on the broader, I think the goal here is to get this information mobile because in the community there's still a large percentage of communities without access to the Internet. So you're starting to hear the use of the phones and texting and all that type of thing as different emergence of technologies to make this information available.

Christine Bechtel – National Partnership for Women & Families – VP

Right, and this is of view and download capability as well.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Again, we just need to make sure that we're flexible in the kind of modalities that are available to provide this information.

Deven McGraw – Center for Democracy & Technology – Director

I get the flexibility piece, especially for people that don't have broadband access because what I'm hearing about people using text, I'm not hearing it so much used to provide clinical information because it's not secure. But people saying your results are available, please call, or something that prompts the patient to take another step where the actual clinical information is more sensitive can be conveyed more securely.

But either way, this is why the issue of the portal first came up, is not to necessarily require that all communications be through a portal, but that that functionality is available for certification so that you have a secure mechanism for communicating with patients and not just in responding to their requests,

but making data affirmatively available to them. But that capability is built into the systems, something that the VA is currently using, something that Kaiser is currently using, CMS uses through My Medicare portal for claims data, so it's not at all unheard of and I think this is why the conversation about looking to portals in stage two of certification came up. So that rather than, while maybe maintaining flexibility with respect to how this happens for meeting certain meaningful use criteria that as a default mechanism you at least should have something in your EHR system that allows you to do this so that you don't, for example, have to use unsecure USB sticks. If you've got a place where you're not connected to the Internet, that maybe we create some exclusions for that.

Marty Fattig – Nemaha County Hospital – CEO

A question for Neil. In your practice when you give the patient something right away, is it paper or is it something electronic you're giving them?

Neil Calman – Institute for Family Health – President & Cofounder

Now, it's paper.

Marty Fattig – Nemaha County Hospital – CEO

That's been my experience as well. When patients want to leave with something they want it on paper. I've yet to have a single patient want anything electronically when they leave the office.

M

The other issue is that the advantage of having it in front of you on paper is it becomes an educational tool. We don't just hand it to them but we actually go over it so that they understand what information is on it. Otherwise they crumple it up and throw it in their pocket or something.

Neil Calman – Institute for Family Health – President & Cofounder

Sometimes they want it to take with them because they're going to see another doctor and they want to hand deliver the record.

Christine Bechtel – National Partnership for Women & Families – VP

Right, and this criteria does not preclude the paper or process at all. In fact, I think it probably supports it because it's helped by being driven from the EHR. In other words, automatically generated so it helps workflow but it does not preclude paper delivery at all. I think what will happen ultimately is that providers will simply integrate that into the more longitudinal view ... and download and the first criteria we talked about. I'm not sure, Paul, what decision, if any, we're trying to make at this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think the only thing really is 24 versus 72, through business days. I do think that when we talked about it in stages one, the three business days did, as someone alluded to, refer to paper delivery. So do we want to leave that as an opening? The majority of folks who at least have patient portals, I mean, it's just going to be part of, it's already there when you leave, and most people, I would agree with both Marty and Neil that most people would like to walk out with something and that typically is a printed version of that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I don't think there's any disagreement about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I still have a question about the 72 hours. Are we basically saying then that providers don't have to give somebody a summary? We're basically saying that if a patient says can I have a summary of this visit that we're saying we'll get it to you within 24 hours is an acceptable answer to that question, correct?

Christine Bechtel – National Partnership for Women & Families – VP

This is the question. We've got discharge instructions on the hospital side. Isn't that clinical summary equivalent to that on the encounter side?

Neil Calman – Institute for Family Health – President & Cofounder

I think it is. And I think, to go back to what Paul said, the content right now is all information that is available at the time of discharge. I guess—

Christine Bechtel – National Partnership for Women & Families – VP

If you don't have to require the note to be there, but even practices are starting to embed that and that should be optional, right?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, if you leave the note out in my mind this should be at the time of discharge the way a discharge summary is. I don't think we should be able to turn to somebody and say, I'm sorry, I can't give you your summary now, give me 24 hours. All kinds of things happen and we're using these as ways of people to know what medications they're on, to review what tests they've had done and everything else. I don't understand why we're not making it available at the time of discharge.

M

... a software function. If you have the software set up to provide certain data set there's no reason why you can't print it out and hand it to the patient when they leave.

Christine Bechtel – National Partnership for Women & Families – VP

As long as there's not data in it that is compromised because of the workflow.

M

Wait a minute. If you go to a specialist, I know that often I'll get a two page letter summarizing my visit and I think that people are afraid that now we're asking those specialists to do that during the patient's visit, when in fact they're seeing 20 patients in a short period of time and then writing all the summaries afterward. That may be what the fear was and why we got those comments back.

M

I get it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think that's—

M

So—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

....

M

... 24 then.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, does everybody agree with 24?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

M

Yes.

M

That's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good. The other question you asked, Christine, was the use of the personal health record. Maybe, Josh, do you want to explain this?

Josh Seidman – ONC

I'm sorry, what's the question you're saying?

Christine Bechtel – National Partnership for Women & Families – VP

There's a line on here about use of PHR to access health data, 20% of patients accessed the system. I just don't know what that is.

W

Yes, I don't either.

Christine Bechtel – National Partnership for Women & Families – VP

I have no memory of discussing a PHR specifically.

Alan

I think the discussion was around taking the view and download, the longitudinal care record, and combining that with the measure that you just discussed and pushing that into a personal health record.

Christine Bechtel – National Partnership for Women & Families – VP

We discussed that that was certainly one option if a patient chose. But as long as you make things like discharge instructions, clinical summaries, the more longitudinal information, the visit summary, as long as those four things have a download capability associated with them. Then the patient could choose to download them either to a PHR, potentially I guess to an HIE, share them with another provider, but that was not a criteria that we discussed having some sort of requirement for patients to actually use the download function.

M

Christine, I think it had to do with the fact that there was uncertainty about whether this is basically the old measure and there was a question about whether if we weren't including the new functionality for the download and the longitudinal, then the other one should become core and increase to 20%.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, but since we are including—

M

So I think if you remember the December conversation there was some question about whether or not to, at that time, to recommend this being core or not and then that's why there were two measures basically, very much related.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we've covered it. I think we would have removed this particular item because it's covered in view and download.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. The remaining three are the ones that we've already agreed on that don't need clarification or simplification, which is the patient resources, secure messaging, and preferences for communication. I just could not remember on communication preferences whether we decided that was menu or core. I think we decided actually it was core, even though we proposed it as menu, but I can't recall.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think, by default, everything we proposed as new would be core. Now that's something ... talking again tomorrow, but our original was that the final rule mentioned that all the existing menu would become core, so I don't know that we would add any new one, at least that wasn't our thought at the time.

Christine Bechtel – National Partnership for Women & Families – VP

No, but we did do that for secure messaging, which would be new but there was such broad support that we agreed that it would be core. I just couldn't recall if we did the same thing for patient preferences for communication.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. I think in our minds everything we added here was core. Again, that's subject to tomorrow's discussion about timing, but that was our original thought.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, great.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, on the access from the hospital, the hospital portal or the view and download, my thought was that we actually had deferred that to stages three, not stage two and/or it's menu versus core. I had a different understanding of that conclusion, although the report didn't show that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's not my recollection.

Deven McGraw – Center for Democracy & Technology – Director

Mine either.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is which one, Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is view and download from the hospital perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is that that 80% one?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

No.

Christine Bechtel – National Partnership for Women & Families – VP

No, it's the visit summary.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Was this already 80% of patients offered the ability to view and download the ... portal within 36 hours, is that the one you mean?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we had considered the possibility of menu but not decided. I don't have anything about stages three, but in stage two all I have noted there is menu, question mark.

Christine Bechtel – National Partnership for Women & Families – VP

Certainly if that is core, the hospital visit summary is core then that would solve our measurement problem on the discharge instructions if we actually integrated the criteria and had the discharge instructions be also delivered through the visit summary mechanisms, but only if the mechanism's core.

M

Yes, but every time we try to combine these things, that's how we ended up with the third one that we just deleted from personal health records. It keeps coming back. Paul, can you –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

My preference on this one would be the discharge instructions people are doing today so let's follow that out. The view and download requires infrastructure to be set up to be able to enable people to set up an account, authenticate themselves. That's where there's work and that's where there's pushback. I'm more on the page with Christine, I don't know if we want to combine them yet, because you still want the view and download capability.

Deven McGraw – Center for Democracy & Technology – Director

Charlene, this is actually a question. How does somebody ... a view and download capability without a portal? What are the mechanisms by which they would do that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

There are other mechanisms to be able to export data from your system in terms of making it mobile. There are now, some of our customers are actually contracting with some emerging technologies, the mobile phones, to be able to provide access to their information. So it's kind of still a view and download, but not a portal that you need a computer for. Maybe it's still logically a portal. It's just making that data accessible when you go in and ask for it. It strikes me that in stage two we might, say, set the account up so they can do that, but we just need to be flexible in terms of having to require a physical portal for everyone.

Deven McGraw – Center for Democracy & Technology – Director

Okay.

M

This is just semantics, but isn't that a portal?

Deven McGraw – Center for Democracy & Technology – Director

Yes, I would have called that a portal too.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It might be. It might be semantics, but people consciously think of a portal as a physical thing.

M

It is a physical thing. If you're accessing it from a cell phone or something, isn't it the same thing? I guess I'm lost. I still don't understand what this alternative technology is that you're describing.

M

If you ship it to a PHR, would that be different than a portal?

M

Yes, that is.

M

So that would be another technology.

M

Right.

Christine Bechtel – National Partnership for Women & Families – VP

Or if you ship it to an HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So we weren't trying to be prescriptive about how you get it to people.

Deven McGraw – Center for Democracy & Technology – Director

But the one common denominator, this is Deven, of the last two or three minutes of conversation is this ability to view and download, so whether it's through a portal, depending on what you think a portal is, or through some other technology, you as the patient have an ability to log on, see something, and grab it.

Christine Bechtel – National Partnership for Women & Families – VP

Right, which means that USB sticks and things I'm not so sure about.

Deven McGraw – Center for Democracy & Technology – Director

....

Christine Bechtel – National Partnership for Women & Families – VP

Yes, it's actually not about the vehicle as much as it is the data, which is the remaining piece, Paul, that I flagged earlier that we do need to talk about, which is both the definitions, what types of data are in there, and how discrete or computable it is. That is a remaining issue that needs to happen because you want to be able to push at the patients and you want them to be able to pull it, which is the download, and aggregate it across the system if they choose.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's correct. We had some of that in our care coordination and some of this would be deferred over to the HIT Standards Committee.

Christine Bechtel – National Partnership for Women & Families – VP

Well, yes, the Standards Committee, right, was going to help us with understanding, once we say that this is the kind of data we want, which we did put in our big spreadsheet that George has, the data types, they would tell us how you get to that data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Christine Bechtel – National Partnership for Women & Families – VP

I agree with that. But I think as we're talking about visit summary and to some degree potentially discharge instructions, we need to understand that it is the view function but the download function probably precludes certain kinds of media, I would imagine. So I think maybe we can figure that out later, but for now I think we have agreement on the criteria in this section, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think so.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Except for the timing, I think, of that one criteria. I've tracked, this is Charlene, the roll out of Kaiser, the VA, all of their capabilities and they've rolled out a portal and have years of that experience and then you provided the view and download functionality. I think the pushback is from the general community to do that is hard to do and it's not to say that they shouldn't do that, but making that a requirement for stage two is a high bar.

Deven McGraw – Center for Democracy & Technology – Director

I guess I'm in the camp of wanting to get public comment on it too. Because as I looked back through the criteria in the other buckets around improving quality, safety, efficiency and health disparities, there are a number of them that are in the core that you could achieve with a portal. So things from recording

smoking status you could get through a portal, or advanced directives, preventive and follow up reminders, things like that. There are lots of stuff that you could get through view and download, kind of secure messaging, through the whole suite of patient engagement criteria. So it actually, I think, sets people up strategically if they do these capabilities now versus in the out years.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, I think we are finished with category two then. Why don't we go on to category five, which is Deven refreshing our memories about the stage two recommendations from the Privacy and Security Tiger Team that went to the Policy Committee.

Deven McGraw – Center for Democracy & Technology – Director

That's right. Those recommendations, most of them are actually more in the certification bucket versus specific meaningful use criteria that, for example, would require attestation from EPs and hospitals. Let me go ahead and go through them and refresh our memories.

One is that with respect to authentication of provider users of an EHR, the Policy Committee adopted a couple of recommendations, one being that the certified EHRs need to have the capability for the two factor authentication that's required to prescribe controlled substances. The other thing that we said was that providers need to have digital certificates at the entity level in order to facilitate electronic exchange of information, such as in the care summary category that we talked about. But that typically happens not necessarily through attestation of meaningful use, but by having the certification process test the use of digital certificates for exchange transactions.

Then with respect to patient access to information, which we described as through a portal but because we really focused on the identification authentication and audit capabilities for the most part, one could foresee that any kind of view and download functionality that requires authentication of the individual patient user. This would apply there as well, we said in this context at a minimum single factor authentication, which is user name and password, ought to be required. But the certified EHR should have the functionality to detect and block programmatic attacks on password or attacks from a known but unauthorized person. There ought to be audit trails deployed for access into the patient online account, how about if we call it that, and that patients should be able to see these on request. There ought to be some provisions for data provenance. In other words, where did the data come from, whether it's a visible date and time stamp or whether it's included in some sort of metadata tag, and what exactly needs to be in the provenance wasn't necessarily decided. Then the portal ought to have an ability for secure download by the patients so that if they wanted to, for example, send it to a PHR that they could.

Then the last set of recommendations are with respect to the security risk assessment and patient matching criteria. The Policy Committee adopted recommendations that once again for stage two providers ought to do or update and since it's stage two it's really update their security risk assessment and address any deficiencies. This is basically a repeat of stages one. But we added a second component to this risk assessment, which is to address encryption for data at rest and then they have to attest that they've done this as part of their security risk assessment. So it's not a flat out requirement to encrypt all data at rest, but is instead just shining a spotlight on the HIPAA security rule obligation which requires providers already to address encryption of data at rest as an implementation The reason for drawing attention to this one particular set of security measures is because of the instances of major breach that have occurred since the notification obligation went into effect, and that two-thirds of these breaches are due to loss or ... data. That was not encrypted and it was all data at rest, so not hacking, but in fact stolen laptops, stolen portable drives, stolen desktop computers.

Then the final set of recommendations was just some instructions really to the Standards Committee to make sure that the recommendations regarding consistent demographic data fields and how data fields are to be populated when information isn't available, such as lack of knowledge of address. Testing for accuracy of those data fields and systems ought to be done in stage two. Again, much of it tied to certification, but some additional attestation requirements with respect to the security risk assessment and some capabilities related to patient view and download.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So this is mostly certification oriented requirements. Any further discussion of this? These were approved by the HIT Policy Committee.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Just a question, is the security risk assessment and the address encryption of data at rest, are those two actual meaningful use objectives and the others are instructions, or have they become objectives? How did you want to structure that?

Deven McGraw – Center for Democracy & Technology – Director

I'm trying to envision how this was handled in stages one, but in general I think if we do what was done in stages one then the two objectives related to the security risk assessment would be actually in meaningful use criteria five and then the certification rule for stage two would include the other stuff. That's actually the way that it worked in stages one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think I agree with that.

Deven McGraw – Center for Democracy & Technology – Director

Yes. Then the other thing that we brought up on our last call was declaring our intent in stages three to look at possibly tying the governance rule to meaningful use in stages three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that's also a good idea. We did talk about that in full committee, not in this last meeting but in previous meetings when NHIN governance was discussed, and that makes a whole lot of sense. Okay, very good. Thank you, Deven.

Deven McGraw – Center for Democracy & Technology – Director

Sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Deven, the recommendation of that online account—

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... more generic word. I like that.

Deven McGraw – Center for Democracy & Technology – Director

Maybe we should do that, "patient online account."

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you, Christine, for walking us through the category two discussion. Art, do you want to go through the lab reporting?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Sure. First of all, I think that there needs to be a little bit more clarity around the other items besides lab reporting. For instance, when we say we're going to move immunizations to core, is it exactly the same wording as in stages one, or are we going to add some threshold for what percent of the immunization

should have been reported? I don't know that it's simply the same wording. As I started thinking about this lab reporting and the suggestion that Neil and Paul had given last week, was how do we do some stepping stones to get people to be doing something more in stages three? I don't think I need to go through them in detail here, but I have proposed them and at some point when we start putting this document together I'd like to add a threshold for stage two regarding the transmission to an immunization registry.

I'll move down to the reportable lab results section. Over the weekend I have had contact with several public health colleagues about the reportable lab results, which is in the eligible hospitals. In stage two there we again would suggest there be a threshold and that there be specific criteria described about what data elements should be reported, because we have not really said much about that in stages one. And that would again play out in stages three.

For syndromic surveillance, I think last week we had a discussion about how the criteria for eligible providers is somewhat weak still. That's still being worked on, but we did make a decision, I think, that the core would apply to the eligible hospitals and that maybe this is not an item for the eligible providers, whether that's still on menu or whether it's actually eliminated and yet to be determined. Again here for stage two I suggest that we have a threshold, that it's not merely the capacity or a test, but that we start to move people in that direction of reporting, giving them a minimum of what we expect to happen.

So I'll move now to the last item, which is what you wanted me to talk about, and we're calling that the capability to provide a mandated public health case report for infectious or non-infectious events that may or may not be triggered by an associated laboratory test. This here, I know last week we had this discussion about will there be menu or core items, and that's something I guess we'll discuss tomorrow, the timing. But if I could have my way, I would suggest this be a menu item in stage two and that just as we did in stages one for the first three items that I just went through, that now we have this same sort of language perform at least one test of certified EHR technologies capability to compile and transmit a mandated public health case report to the jurisdiction where it applies. Then in stages three that would move to an electronic report and there would be a threshold.

So I know that, Paul, you asked me to describe in a matrix format, and I don't know how to share what I've done with the group at this time, whether I send that out to everybody or what you would like for me to do regarding that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You certainly can send it to everybody. Is it easy to walk through on this call?

Josh Seidman – ONC

Maybe we could address it tomorrow. I know that Jim Daniel will be able to participate tomorrow, he's not on right now, and he might be able to help as well.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Right. We could do it tomorrow. Certainly we want Jim to be a participant in this, Paul, so I think maybe Josh's suggestion is appropriate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm just a little worried about the time. I don't know that we have any agenda time allocated for this. Can you send out the matrix at least today and—?

Art Davidson – Public Health Informatics at Denver Public Health – Director

Yes, sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think one of the questions you're raising is the threshold for all of these. I guess one of our challenges, certainly for stages one and I'm not sure if it's changed a whole lot for stage two, at least stage two for 2011, was the ability for even the majority of public health agencies to accept it.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Again, anywhere where in stages one we wrote, those clauses all still apply. So we're not trying to say that you can be held accountable if your public health department is incapable of doing this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But didn't we say if they can and your tests are successful, then you should be submitting electronically? Is that the same thing as a threshold in a sense?

Art Davidson – Public Health Informatics at Denver Public Health – Director

You could send it once and then it doesn't really get to the point of where we have a threshold that says whatever that threshold is, if you sent it 25% of the time or you sent it 80% of the time. I think the public health should be looking at these criteria the same way that we have for all the others, is where possible go from attestation to reporting a number to actually meeting a threshold.

Neil Calman – Institute for Family Health – President & Cofounder

It seems to me that the threshold has a different meaning here. If you're linked up to be able to upload information to a health department for syndromic surveillance, you literally go from zero to 100%. You're not going to just upload every other day or every third day or whatever. Similarly for electronic reporting of immunizations, if the immunizations are in your system and you're electronically reporting them, then you're electronically reporting all of the immunizations or all of the immunizations at least at the registries allowing you to report. I don't think that the thresholds have the same meaning here as they have in some of the other things that we've done.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I think you could look at it that way, Neil. But I also think that you could say, well, if I got the patient to view and download their electronic discharge summary a couple of times and it broke, I don't have any responsibility to fix it and I still get my money.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But what's the incentive for people to have something stop working and then just ignore it?

Neil Calman – Institute for Family Health – President & Cofounder

The threshold's 100%, in my mind. We're either saying you hook up if it's capable and we're expecting you to report, or you don't. But to say we're expecting you to report half the time or whatever it is, that doesn't make any sense to me for some of this stuff.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I was thinking that some of them would be in that year, they would report that it took them a while, it might have taken them nine months to get that reporting and then finally the last three months of the year they had it running.

Neil Calman – Institute for Family Health – President & Cofounder

That's a different thing than the—

Art Davidson – Public Health Informatics at Denver Public Health – Director

That's the 25% of all immunizations have been reported for that year.

Neil Calman – Institute for Family Health – President & Cofounder

I think this gets back to Paul's timing thing. If we're going to say that, we should say that you're linked up to the immunization registry to report all immunizations for at least three months in the reporting period.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I agree. I may not have the right wording here.

Neil Calman – Institute for Family Health – President & Cofounder

Anyway, that's—

Art Davidson – Public Health Informatics at Denver Public Health – Director

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

The other question I had for you is, you kept alluding to the fact that is this something that's literally going to develop with different working standards everywhere in the country?

Art Davidson – Public Health Informatics at Denver Public Health – Director

"This" meaning which part?

Neil Calman – Institute for Family Health – President & Cofounder

Let's just say the communicable disease reporting.

Art Davidson – Public Health Informatics at Denver Public Health – Director

We're working with CDC and CSTE to figure out what would be that base report, that minimum generic report. There is not one now, and that would be something that we would have to work with the Standards Committee to promote. But we do not want this to develop in 3,000 different jurisdictions in 3,000 different ways.

Neil Calman – Institute for Family Health – President & Cofounder

So the Standards Committee would develop the standards for these reports?

Art Davidson – Public Health Informatics at Denver Public Health – Director

That's right. This is not intended to be the complete case report. This is intended to be a step toward case reporting. Case reports for hepatitis are different than varicella, as you know, Neil, so the criteria are very different. But there should be a base set of data, it's 6 elements, 12 elements, whatever it is, that say the condition, the name of your condition, the name of the patient, their address, the jurisdiction, the phone number, the medicine. Whatever those base things are decided by CDC and CSTE with the Standards Committee giving the affirmation that this is what we're headed toward, that would be what we're looking at, not each jurisdiction does its own thing. That would be a mess. That would be impossible for the vendors.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So I guess that's the question being called, in 2011 or 2012 does this already exist? And if not, how do we make it something that's certified in both the EHR systems and used by providers?

Art Davidson – Public Health Informatics at Denver Public Health – Director

That's what CSTE (the Council of State and Territorial Epidemiologists) and CDC are working on now. It does not currently exist. I've been canvassing public health colleagues about that and that's the piece that needs to be completed. There are a few IHE implementation guidelines that could be used, but it's not for all areas yet. So there would need to be some work here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How do we avoid inadvertently causing 3,000 reports to bloom before the agreed upon standards exist?

Art Davidson – Public Health Informatics at Denver Public Health – Director

In stage two, the suggestion is that, and this is having worked with Seth Foldy over the weekend, is that there be at least one condition for which the public health jurisdiction has adopted a national implementation guide. There are these national implementation guides done by IHE and we could say that if you have, you attest to, if I've had anything in these categories, and mostly right now it's around cancer, if I've had anything in this category I need to report it. If I haven't had one, I have the method to say this does not apply to me. I didn't have a cancer case. I don't have cancer patients. So we could go with one of the national implementation guidelines that exist. It's not as complete as we would really like and maybe the others will come along in the meantime, but there are a few out there right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We're hoping that with the National Quality Strategy, for example, and things going on in other HHS initiatives, that by stages three anyway there are certainly more than one, both areas of emphasis. We can pick on those, but I think getting started with one, where an IT standard or implementation guide already exist, will be a good march in that direction. That is part of tomorrow's discussion meeting, how do we piggyback on special areas of interest for the quality strategy, and maybe you could think a little bit about that and propose that one that you're suggesting for tomorrow to get us started.

Art Davidson – Public Health Informatics at Denver Public Health – Director

It sounds good, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, super. Then we have new one, which is the patient generated data submitted to the public health agencies.

Art Davidson – Public Health Informatics at Denver Public Health – Director

I don't really know that in stage two that's going to happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director

So that's really something that probably we could put on the back burner at this point.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that's appropriate and it also is consistent with what the Quality Measures Workgroup is doing. There are things they're trying to find in the area of patient generated data, but I think most of those are going to be stages three, just because they don't exist right now.

Art Davidson – Public Health Informatics at Denver Public Health – Director

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Art and Paul, I was trying to take notes, but for this one I'm waiting for Art, you to send that matrix before I modify those other three. And I just noted on patient generated data Is that correct?

Art Davidson – Public Health Informatics at Denver Public Health – Director

That's correct, George, and I'll get you the matrix that we've been working on over the weekend.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments about public and population health? I see in our notes, the summary notes that ONC staff provided, the PowerPoint with the colors, that we did talk about in care coordination that we were going to work a little bit more on the longitudinal care plan. That was something we were a little nervous because I don't know that the longitudinal care plan has been defined. But was there some follow up that somebody was going to provide, at least for our meeting tomorrow?

Josh Seidman – ONC

Yes. ..., I think I sent you on Friday that

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Josh, we can't hear you very well.

Josh Seidman – ONC

I'm sorry. I thought I had sent the document

Judy Sparrow – Office of the National Coordinator – Executive Director

I sent out this morning three documents for tomorrow, I believe, including I guess the PowerPoint, the aftercare summary—

Josh Seidman – ONC

There's one more document, if I didn't send it to you I'm sorry, but I can send that out.

Judy Sparrow – Office of the National Coordinator – Executive Director

Send it me and I'll get it out this morning.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Paul, are we missing any of the subcommittees we created for the first category? And we can do it tomorrow, but I just want to remind us that we set people up to fix stuff in category one—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and does anybody—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... and one of them was CPOE, for example.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let's see here.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That was the thing I e-mailed you about radiology and labs, which may not have gone out to the group.

Christine Bechtel – National Partnership for Women & Families – VP

No, I don't think it did, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Charlene and I looked at it, so we should circulate, whether we accept it or not we should circulate that. My question is, were there other groups that also had homework that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

... we collected?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Josh, do you have a list of those?

Josh Seidman – ONC

Sorry, say it again?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We had some special topics that we tabled in our—

Josh Seidman – ONC

Of the small groups?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Josh Seidman – ONC

... I think the second to the last slide—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Got it. That's slide 14.

Josh Seidman – ONC

Oh, I'm sorry. Let me go there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Who was working on CPOE, the denominator and thresholds for lab, rad orders?

Josh Seidman – ONC

Yes, we did that. That's the one I sent to you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So I guess we'll need to send that out. Family health history, was anybody working on that? I think what we decided at the time when we talked about it was we all support that and we currently go to the existing, oh, I see, so there's another piece of that that Charlene was going to provide about what actually does exist in most EHRs currently. That was one of the inputs. Is that something we'll have tomorrow?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, I'm working to try and finalize or get as much input as I can by the end of today.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Was anybody working specifically on family health history? What we left at was we unfortunately had to postpone that to stages three because of the absence of both standards and tools to do that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, the general comment I got from the vendors is pretty much they all capture it, but they all capture it—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In different ways.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

... in whatever format they capture it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So we could add that as stages three so that we certainly put that in as a signal and ask the HIT Standards Committee to understand what currently exists, if there's anything even in the works. Structured labs, we talked about—

M

The Standards Committee is going to be working on that but, as you say, obviously there's a lack of standardization and it will be hard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

George has something for CPOE that he'll distribute, family health, if you'd just give us that line about it's already on the docket for the Standards Committee, that's helpful. For structured lab data we did not require LOINC and I think a lot of people want LOINC to be in there. That's again something we can

spread an opinion on and pass it to Standards. Where we left it, I believe, is that LOINC doesn't cover the full gamut, but if we can at least come up with a list of things that should have LOINC codes in it, that would be helpful. With eMAR, that was a where are we kind of thing, with the inpatient system.

Christine Bechtel – National Partnership for Women & Families – VP

It's in my notes. I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The thought was that they'll have them and are using them. We just want to validate that because there was a little pushback in the public comment.

Christine Bechtel – National Partnership for Women & Families – VP

I think the conclusion was that it was in use in at least one unit, I think is where we ended up with the threshold.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Patient preferences, that was where everybody supported ..., listed in the categories. Maybe that's just us passing it over to the HIT Standards Committee. In the past what we've done is do the open print ED kinds of things, and we may want to finish that up. The patient specific education resources, this was a question where, yes, there's an info button standard at HL7, correct, Josh?

Josh Seidman – ONC

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We didn't specifically call out for it, but I guess HIT standards could.

Josh Seidman – ONC

The Standards Committee is working on it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Another one-liner would help us there. Do we have outstanding items here? I think that sort of covers it.

Deven McGraw – Center for Democracy & Technology – Director

Paul, I recall that there was an earlier conversation, and actually now I'm getting information exchange and meaningful use confused. So if this comes up in meaningful use you can just feel free to shut me right down, but someone raised the issue of declaring the standard between CCD and CCR, and I said that I didn't feel comfortable doing that and wanted to get some additional information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So it did come up during the Policy Committee actually, someone mentioned, hey, look, standards are nice if you need to pick one to make it useful, so that was just a comment that was made during our discussion. Do you know, Josh, whether that is being discussed again at the Standards Committee?

Josh Seidman – ONC

Yes. Just to let you know, the document that will be coming to you, looking at the different elements on the longitudinal care ... and so forth, does go through both CCR and CCD. So that will be for your reference as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So if it is desirable to pick one—

Deven McGraw – Center for Democracy & Technology – Director

Standards do it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Josh Seidman – ONC

Yes, and I think that they are working on that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so that's another, just if they'd let us know that that's happening that will take that off our plate and ... the appropriate plate. But I think the feedback happened after the Policy Committee said, you know, the problems persist when there are multiple standards.

Deven McGraw – Center for Democracy & Technology – Director

Right, but that's what the Standards Committee's job is, is to say whether or not one should be declared in that circumstance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Deven McGraw – Center for Democracy & Technology – Director

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Anything else? Okay, well then this left over about the care coordination and the longitudinal care plan, the issue is how do we define that? I think Eva had talked about some of that. David Bates' initial thought was needing to defer to stages three only because we didn't have standards for stage two. Is there any information that would differ from that?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, Paul, I've got some background noise. I apologize. But on our last call we actually moved away from that position and we talked about how we can get some of the basic things that are core elements of a core plan done in stage two. So I know that Eva's worked a lot on that and we can be prepared to talk about that tomorrow, but we actually moved away from that notion. I remember that David was saying that's good that he was glad that we were thinking about how to do it practically in stage two given the wealth of information that we were already asking for under some of the patient and family engagement criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So is that something potentially you can introduce tomorrow?

Eva Powell – National Partnership for Women & Families – Director IT

Yes, Paul, this is Eva. I'll come prepared to have some recommendations.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, wonderful. Thank you. Okay, I think that sums it up, unless anybody else has additional things, at least for today? Again, tomorrow we're going to focus on making sure we take a step back, a step higher, and look at the whole program, wanting to continue the momentum and making sure that we're not adding unnecessary burden. Then to reconcile that with the new HHS programs that have come up just in the past month since we came up with the first draft. Then the second major piece is how do we deal with timing, again the same kinds of things. We want to maintain the forward momentum. We need to stretch ourselves and the industry without causing undue burden and doing things prematurely that could ... having 3,000 things going on instead of a standardized way of communicating information that everybody understands.

If there's nothing else, then we will open it up to public comments. We're meeting at 9:00 in Switzer.

Judy Sparrow – Office of the National Coordinator – Executive Director

Right. Operator, can you see if anybody wishes to make a public comment?

Operator

(Instructions given)

Judy Sparrow – Office of the National Coordinator – Executive Director

Just to remind everybody, Switzer is a federal building, so you might want to come a little early. There's a little bit of a process getting in the building.

Operator

We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, thank you. Thank you, Paul and everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you, everyone and see you tomorrow. Take care.

M

Thank you. See you tomorrow.

Public Comment Received During the Meeting

1. In an effort to avoid the "blooming of 3000 stds", it might be a good idea to specify a std reporting vehicle for reportable health events - Direct project specifications
2. It may be worth considering the difference in security between paper, pen drives, CD's, etc. when providing the patient encounter data.